

TerraNova Homes & Care Limited - Brittany Residential Care

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: TerraNova Homes & Care Limited

Premises audited: Brittany House Residential Care

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 12 June 2017 End date: 13 June 2017

Proposed changes to current services (if any): This audit also included verifying the service as suitable to provide residential disability- physical level care

Total beds occupied across all premises included in the audit on the first day of the audit: 50

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Brittany House residential care is part of TerraNova Homes & Care Ltd. The service currently provides care for up to 62 residents. The service is certified to provide hospital (medical and geriatric) rest home and residential– disability level care. On the day of the audit, there were 50 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management and general practitioner. This audit also included verifying the service as suitable to provide residential disability –physical level care.

TerraNova has robust quality and risk management systems implemented across its facilities. Across TerraNova, benchmarking is well established. Annual goals for the facility have been determined, which link to the overarching organisational plan.

The facility manager (RN) has been in the role since February 2017 and has many years' experience in aged care management. The clinical coordinator (RN) who is also very experienced has been in the role since late January 2017 and previously worked for several years in aged care in Australia. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

In December 2015, the first-floor lounge and dining area were extensively refurbished and hallway carpets were replaced. One room downstairs was being refurbished at the time of audit and was not in use.

The service is commended for achieving a continued improvement rating for the activity programme. This audit identified improvements are required around open disclosure and the call bell system.

Consumer rights

<p>Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Brittany House Residential Care endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are actively managed and well documented.

Organisational management

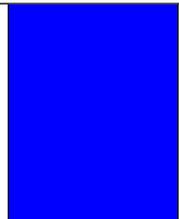
<p>Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.</p>		<p>Standards applicable to this service fully attained.</p>
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Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager and clinical coordinator are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of quarterly and annual reviews. A risk management programme is in place, which includes managing adverse events and health and safety processes.

Brittany House Residential Care is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality corrective action forms/education, demonstrate a culture of quality improvement.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Service information is provided to residents and family on admission to services. The service utilises a computer-based assessment, care planning and progress noted system. Resident records reviewed provide evidence that the registered nurses utilise the interRAI and additional computer-based assessments to assess, plan and evaluate care needs of the residents on the computer. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration

and are reviewed at least six-monthly. Resident files include three-monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines and medications are recorded using paper based system. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner.

A varied activities programme is in place for the rest home, hospital and younger residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

The menu is designed and reviewed by a registered dietitian and all meals cooked on-site. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen occur.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant. Electrical equipment has been tested and tagged.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings and restraint steering group meetings at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers. On the day of audit, the service had five restraints (four bed rails and one lap belt) and four residents with bedrails as an enabler.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control resource nurse is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control resource nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and

surveillance of infection control events and infections. The service engages in benchmarking of infections with an external provider. Staff receive ongoing training in infection control.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	47	0	2	0	0	0
Criteria	1	98	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in visible locations. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (six caregivers, two registered nurses, one enrolled nurse, facility manager, clinical coordinator, physiotherapy assistant and one activity coordinator), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are procedures in place for informed consent and resuscitation and the service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Policies include informed consent policy, advocacy policy and guidelines for resuscitation.</p> <p>There were signed general consents including outings and resuscitation status in all seven resident files sampled (three rest home and four</p>

		<p>hospital level of care residents- including one resident under the respite contract and one YPD resident). Resuscitation treatment plans and advance directives were appropriately signed in the files reviewed.</p> <p>Discussions with staff confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms.</p> <p>Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative's lives.</p> <p>Informed consent processes and family/resident care plan updates are also reviewed through the six-monthly MDT.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held monthly. The service works with their YPD residents to encourage continued involvement with community groups (link to 1.3.7.1).</p> <p>Many of the hospital residents have high physical needs, so often it is more appropriate to support family, friends and community groups to come into the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives on entry to the service. The facility manager maintains a record of all complaints, both verbal and written, by using a complaint register. Complaints are documented on the organisation's electronic system (People Point). These are also monitored by head office.</p> <p>Discussions with residents and relatives confirmed they were provided</p>

		with information on complaints. Complaints forms are in a visible location at the entrance to the facility. Six complaints received in 2016/2017 YTD were reviewed, with evidence of appropriate follow-up actions taken. Caregivers interviewed commented that complaints are part of the meeting agenda and are discussed at various facility meetings. There is a recent HDC complaint that the service has responded to and awaiting response.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The facility manager, the clinical coordinator and registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All nine residents (six rest home level, two hospital level and one YPD) and five relatives (two rest home and three hospital) interviewed, report that the residents' rights are being upheld by the service. Staff interviewed were familiar with the Code of Rights.</p>
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff have received training. There are three double rooms and three four-bedded rooms in the facility. All shared rooms have curtains between bed spaces to protect resident's privacy and dignity.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Eight residents identifying as Māori are living at the facility.</p>

		<p>Māori consultation is available through the documented iwi links and Māori health services. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. There are guidelines for understanding the Māori culture as it relates to health (Te Whare Tapa Wha). All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p> <p>The residents welcomed the audit team with a Powhiri ceremony on the first day of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and they are incorporated into the residents' electronic care plans. All residents and relatives interviewed confirmed they were involved in developing the resident plans of care, which included the identification of individual values and beliefs. There are spiritual, religious and cultural standard operating procedures (SOPs) to guide staff. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. Interviews with staff and management evidenced the orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Interviews with staff confirm their understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service promotes evidence-based practice and encourages good practice. Registered nursing staff are available 24 hours a day. A house GP visits the facility at least once per week. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist visits. Physiotherapy services are provided on-site four hours per week, with the support of a physiotherapy assistant five hours per day Monday-Friday. There is a regular in-service education and training programme</p>

		<p>for staff. The service has links with the local community and encourages residents to remain independent.</p> <p>An annual organisational education planner was rolled-out in January 2016 by the organisation and updated in 2017. These sessions are being delivered as planned in the care home including opportunistic education around areas of development identified by clinical coordinator and facility manager that require extra training (eg, stoma therapy training when there was a resident with a colostomy or following incident/accident analysis). Six of seven qualified staff and nine caregivers have completed the Fundamentals of Palliative Care certificate. This involved 12 modules to be completed by the staff both through training and online resources. The manager advised that completion of this has also had the added benefit of creating a strong relationship with the local hospice.</p> <p>TerraNova has established benchmarking across its sites. There is a strong commitment to quality improvement at Brittany House and across the organisation. Improvement initiatives and quality goals are identified involving staff and are regularly reviewed. Steering groups for restraint, infection control and H&S are being implemented at an organisational level.</p> <p>Risk management reports are completed for residents at risk and service delivery risks such as (but not limited to): incidents/accidents; residents with pain; unexplained weight loss; and identified depression. Action plans are implemented to minimise the risk and processes reviewed and evaluated. The risk management report is provided to head office and discussed and shared through manager teleconferences.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>PA Low</p>	<p>Standard operating procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is an open disclosure policy.</p> <p>Accident/incident forms and electronic records of incidents (on People Point) have a section for staff to indicate if next of kin are to be informed (or not) of an accident/incident. Not all accident/incident forms or corresponding progress notes reviewed (from May 2017), identified</p>

		<p>family were kept informed. Relatives interviewed reported that they are contacted when there is a change to treatment of care, or if there has been an incident.</p> <p>Cultural appropriateness includes interpreter services.</p> <p>Staff could describe how interpreter services can be accessed. The information pack is available in large print and read to residents who require assistance.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health 'Long-term Residential Care in a Rest Home or Hospital – what you need to know' is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Brittany House Residential Care is part of TerraNova Homes and Care Ltd. The service currently provides care for up to 62 residents. The service is certified to provide hospital (medical and geriatric) and rest home level care. This audit also included verifying the service as suitable to provide residential disability –physical level care.</p> <p>On the day of the audit, there were 50 residents. There were 27 hospital residents (including 2 YPD residents, 2 hospital respite, 1 mental health and 1 resident under ACC). There were 23 rest home residents (including 4 long-term chronic and 2 YPD). There are 55 dual purpose beds which split between both floors. The majority of the hospital residents were located on the first floor of the building.</p> <p>The organisation has a vision, mission statement and objectives. There is an organisational business plan that links to the site-specific quality goals and objectives. The CEO reports to the board two-three monthly.</p> <p>Annual goals for the facility have been determined, which link to the overarching organisational plan. Quality goals for 2017 include: (i) to reduce the use of restraint by 65% (based on 2016 numbers); (ii) to reduce by 50% the rate of infections incidents; (iii) that 90% of newly employed FT/PT staff and will have completed a L2 certificate in Health & Wellbeing 90 days post start date by end Dec 2017; and (iv) increase</p>

		<p>by 50%, staff attendance to internal education (based on 2016 numbers). Progress to meeting goals are regularly reviewed through meeting minutes.</p> <p>The managers across TerraNova teleconference weekly as a group with the CEO. One of the key focuses of the organisation is transparency and learning. Weekly teleconferences between managers and clinical managers, provides that opportunity. A monthly risk management report is completed at Brittany House Residential Care; review/outcome is completed as part of that report and monitored by head office.</p> <p>The facility manager (RN) has been in the role since February 2017 and has previously worked in aged care management roles. The clinical coordinator (RN) has been in the role since February 2017 and has many years' experience working in Australia in aged care. Staff spoke positively about the support/direction and management of the current management team.</p> <p>The facility manager and clinical coordinator have maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>A clinical coordinator/registered nurse (RN) who is employed full-time, supports the facility manager and steps in when the facility manager is absent. The TerraNova CEO and clinical quality & risk advisor visits regularly and supports both managers. The clinical and quality risk advisor was on-site on day two of the audit.</p> <p>The service's operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and promotes quality of life.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management programme is well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems.</p> <p>TerraNova's policies, procedures and relevant forms are available both in hard copy and online under "Share Point" (intranet). Review of clinical policies and procedures is coordinated by the clinical quality and risk advisor (CQRA) in conjunction with the managers and clinical</p>

	<p>coordinators. Approval of the amended/new document involves the executive management team before uploading and release of the document.</p> <p>Updated documents are released/supplied to the facility. A memo is sent to the managers along with printed copies of relevant documents for filing in their master hard copy folders. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place.</p> <p>TerraNova has robust quality and risk management systems implemented across its facilities. Across TerraNova, benchmarking is well established. The online 'ZAP reporting' system has been set up which pulls data/clinical indicators from 'People Point' (electronic system). This gives a more thorough analysis and is monitored by the TerraNova clinical quality & risk advisor who supports the managers at Brittany House Residential Care to further analyse the data and introduce corrective actions where needed.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): resident falls; infection rates; complaints received; restraint use; pressure injuries; wounds; and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed.</p> <p>A residents meeting occurs two monthly and an annual resident survey is completed. The last survey identified 96% overall satisfaction with the service. Quality projects were implemented as a result of suggestions from the resident's meetings (link to 1.3.7.1).</p> <p>Interviews with staff and review of meeting minutes/quality corrective action forms/opportunist education sessions, demonstrate a culture of quality improvements.</p> <p>Falls prevention strategies are in place. A health and safety system is in place. Health and safety is an agenda item of the staff meeting.</p>
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		<p>Hazard identification forms and a hazard register are in place. Health and safety management has been improved with organisational three-monthly health and safety meetings, the appointment of a health and safety officer and rep and a focus on reducing hazards and promoting safe work habits amongst employees.</p> <p>Three steering groups at an organisational level have been implemented including a restraint, health and safety and infection control group. A representative from Brittany House Residential Care attends each of the organisational steering groups.</p> <p>A robust risk management system is in place with the clinical coordinator completing a monthly report with corrective actions. Incident management is well managed, with all incidents being reported on 'People Point' and reviewed by the clinical coordinator and facility manager (FM) on a daily basis. Incidents are also able to be reviewed in detail by the CEO and CQ&R advisor on 'People Point'.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Fifteen accident/incident forms were reviewed (from May 2017). Accident/incident forms and electronic records of incidents (on People Point) identify follow up by a RN. Each event involving a resident reflected a clinical assessment and follow up by a RN. Incidents are benchmarked and analysed for trends. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications and provided examples.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (facility manager, clinical manager, RN, two caregivers and one activity coordinator) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates is maintained.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN</p>

		<p>and support staff) and includes documented competencies. New staff are buddied for a period of time and during this period they do not carry a clinical load. The orientation booklet aligns with NZQA foundations level two and staff have ninety days to complete. On completion of this orientation, they have effectively attained their first national certificates. From this, they are then able to continue with core competencies level three unit standards.</p> <p>The 2017 education plan is implemented. Education sessions are being delivered as planned in the care home including opportunistic education around areas of development, identified by clinical coordinator and facility manager, that require extra training (eg, when a resident was admitted with a genetic disease, or following incident/accident analysis). Specific education has been provided in relation to the current needs of their young people (YPD). Education and training for clinical staff is linked to external education provided by the district health board. The service has well exceeded over eight hours of training provided annually.</p> <p>A competency programme is in place with different requirements according to work type. Core competencies are completed annually and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). Competencies include (but not limited to): cultural; glucose monitoring and insulin; fire safety; medication; manual handling; controlled drug checking; restraint; SC administration; infection control; and wound care.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing levels meet contractual requirements. The facility manager and clinical coordinator are available during weekdays and on call out of hours.</p> <p>There is a registered nurse on duty on each shift, seven days per week and they are based on the first floor. An enrolled nurse/team leader (senior caregiver) is on duty on the ground floor on each shift, seven days per week.</p> <p>Additionally, for 27 residents (12 rest home and 15 hospital) on the first floor; there are four caregivers on duty on the morning shift, three on the afternoon shift and at night there is one caregiver on duty.</p> <p>For 23 residents (15 rest home and 8 hospital) on the ground floor;</p>

		<p>there are two caregivers on duty on the morning shift, two caregivers on the afternoon shift and one caregiver at night.</p> <p>The rosters reviewed evidenced an increase in staffing with an increase in occupancy and vice versa.</p> <p>A physiotherapy assistant works 08.30 am - 1.30 pm Monday – Friday. The activity coordinator works 08.30 am - 4.30 pm Monday- Friday.</p> <p>Staff, family members and residents interviewed reported that there were enough staff on duty to meet resident needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. All staff have access to areas relevant to them on the People Point electronic system. Electronic records are protected from unauthorised access. Hard copy records are held securely.</p> <p>Residents’ files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation. Electronic records clearly identify staff member and time.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures in place around entry to services. The service provides an information pack on entry to services.</p> <p>Registered nurses assess all residents on entry to service. RNs interviewed were able to describe the entry and admission process. The GP is notified of a new admission.</p> <p>Eight signed admission agreements were sighted and all had been signed. The agreement aligns to the service contracts and exclusions from the service are included in the admission agreement.</p> <p>There are policies and procedures in place around entry to services. The service provides an information pack on entry to services.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and use of the DHB</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>'the yellow envelope' is used to improve admission and discharge information to and from public hospital. The RNs report that they include copies of all the required information in the envelope.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors recorded are fed back to the supplying pharmacy.</p> <p>Registered nurses, enrolled nurses and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Caregivers who act as a second checker also complete a medication competency. There were no self-medicating residents on the day of audit. The two medication rooms were observed to be clean and well organised, all medications were in date and stored appropriately. The medication fridge had temperatures recorded daily and these are within acceptable ranges. Medication trollies are stored in a locked medication room on each floor.</p> <p>Sixteen medication charts were reviewed (included a sample of rest home, hospital, respite, young person's disability and long-term chronic health condition charts). Photo identification and allergy status were documented on all charts. All medication charts had been reviewed by the GP at least three-monthly. All resident medication administration signing-sheets corresponded with the medication chart. The medication round was observed during the audit and the process was noted to be correct and safe.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The residents' individual food, fluids and nutritional needs are being met. Residents are provided with a balanced diet, which meets their cultural and nutritional requirements. The meals are cooked on-site in a well-equipped kitchen. Residents interviewed reported they are satisfied with the service.</p> <p>There is a four-weekly seasonal menu reviewed by a registered dietitian. A dietitian visits as required. A dietary assessment is completed on all residents at the time they are admitted and updated if there is a change in need. Residents with special dietary needs have these needs identified. Resource information on these diets is available</p>

		<p>in the kitchen. Resident meetings discuss food and feedback is given. Special equipment is available such as lipped plates. Lunch meals were observed. Staff were observed assisting residents with meals.</p> <p>The kitchen was observed to be clean and well organised and all aspects of food procurement, production, preparation, storage, delivery and waste disposal complied with current legislation and guidelines.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry were declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The facility has embedded the interRAI assessment protocols within its current documentation. The interRAI initial assessments and assessment summaries were evident in printed format in all files. The facility's own computer software includes a wide range of assessments that are used to develop the care plan. The interRAI assessments are also used to develop the care plans. All seven permanent resident files included an up-to-date interRAI assessment and computer-based assessments.</p> <p>Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents with documented pain and also residents requiring administration of controlled medication as part of prescribed pain management plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The facility uses an electronic-document management system where the RNs and caregivers write their progress notes in the resident file on the computer. The GP and allied health providers documented their clinical and care notes in the paper-based resident files.</p> <p>All eight resident files reviewed have an electronic-based long-term care plan and a care plan summary in place including the respite resident who had a documented care plan. Assessments link to the care plan. The service has computer terminals in each of the three nurses' stations as well as management offices. RNs and caregivers interviewed stated they have access to the resident files. This was also</p>

		<p>observed on the days of audit.</p> <p>The clinical coordinator is currently peer reviewing care plans and providing feedback to each RN on an individual basis. All resident care plans were individually focused. Family members interviewed agreed that they have been involved in the care planning development and review process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>All resident files reviewed had care plans in place. When a resident's condition changes the RN initiates a GP visit or nursing specialist referral if required. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Continence products are available and resident files included a three-day urinary continence assessment for resident with continence issues, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.</p> <p>Wound care plans were electronic-based, the template included an assessment, wound management plan and evaluation forms. All fields in the electronic wound care documentation were comprehensively completed.</p> <p>Seventeen wounds (two PIs, two chronic ulcers, six skin lesions, four skin tears, two cellulitis and one hematoma) were documented on the day of audit. All pressure injuries were documented to be healing.</p> <p>Monitoring charts were in use and examples sighted included (but not limited to): weight and vital signs; blood glucose; pain; food and fluid; repositioning charts; and behaviour monitoring as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>Brittany House employs a full-time activities coordinator who assists and oversees the programme. The service also employs two activities assistants who work part-time and the service is supported by a number of volunteers. This team provides activities seven days a week.</p>

		<p>A wide range of activities, addressing the abilities and needs of residents in the hospital and rest home are offered. Activities include physical, mental spiritual and social aspects of life to improve and maintain residents' wellbeing. The monthly programme timetable is distributed to all residents. Colourful posters are displayed to remind residents of what's on.</p> <p>On admission, an activity coordinator completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There are volunteers that assist with a variety of activities including van outings.</p> <p>Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Monthly meetings are held where residents and relatives nominate activities of their choice to be added to the monthly programme, examples include: daily exercise; development of a herb garden; and fundraising appeal for pets at local society for prevention of cruelty to animals. Minutes are recorded at the forum, quality improvements identified and feedback given.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The resident files reviewed identified long-term care plans had six-monthly reviews completed and were updated when needs changed. Clinical reviews were documented in the multidisciplinary review (MDR) records, which included input from the GP, RNs, activities coordinator, allied services and resident/family. Evaluation of the care plan at (MDR) meetings assesses achievement towards the desired goal or outcome. Progress notes were completed on the computer and reflected response to interventions and treatments. Changes to care were documented. Documentation of GP visits evidence that reviews were occurring at least three-monthly. Short-term care plans were in use for short-term issues and evidenced signed off once completed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	<p>FA</p>	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance from specialist practitioners. The review of resident files included evidence of recent referrals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies and procedures that guide the safe and appropriate storage, transport and disposal of waste and hazardous substances. Waste is appropriately managed.</p> <p>Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety datasheets were available throughout the facility and accessible to staff. Chemicals were observed to be secured safely. Safe chemical handling training has been provided. Personal protective equipment/clothing is freely available.</p> <p>Staff interviewed demonstrated knowledge of handling chemicals.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Brittany House is currently refurbishing and upgrading the facility. The building has two storeys. The ground floor has two wings; Pampuri wing has twelve bedrooms with two resident bathrooms requiring repair. The other wing has nine bedrooms. The ground floor has one room under refurbishment (currently suitable for a rest home resident) that was not in use.</p> <p>The first-floor level has four wings. St Anne's wing has four single rooms, one double room and two three bedded rooms and Our Lady wing has seven single rooms and one resident bathroom. St Peters wing has eight single rooms and St John's wing has six single rooms, one double room and two three-bedded rooms.</p> <p>The building holds a current warrant of fitness displayed, expiring 1 January 2018. Fire drills occur six-monthly. A preventative and reactive maintenance schedule is in place and accurately maintained for the service. Hot water temperatures are monitored and recorded monthly. Where temperature has exceeded 45 degrees, the service has implemented corrective actions. Electrical equipment is tested and tagged. All hoists have been checked and serviced and medical equipment has been calibrated and checked. All hazards have been identified in the hazard register. The hazard register is reviewed</p>

		<p>monthly and signed off.</p> <p>Residents were observed moving easily around the building with walking aids, wheelchairs and independently.</p> <p>There are outside courtyard areas with seating, tables and shaded areas that are easily accessible.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms have hand-washing facilities with soap dispensers and paper towels. All single resident rooms have a bathroom with shower and toilet. Upstairs there are two communal bathrooms (St Peters wing and Our Lady's wing) with a total of seven communal showers and one communal bath altogether. Each communal bathroom is located centrally and shared between two wings. Communal bathroom and toilet facilities have a system that indicates if it is occupied or vacant. Privacy is further maintained by additional curtains behind doors in some areas. Equipment includes shower chairs and commodes.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents' rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. One resident room on the ground floor is under refurbishment and was not in use. There is a large lift between floors. Transfer of residents can occur on an ambulance stretcher and equipment can be transferred between rooms. Mobility aids can be managed in communal bathrooms.</p> <p>Rooms can be personalised with furnishings, photos and other personal adornments and the service encouraged residents to make the room their own.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has a large central hub (formerly a chapel) on the ground floor where most activities take place. There are two large dining rooms, one upstairs and one downstairs. St Anne's wing and St John's wing each have two smaller lounges. Furniture in all areas is arranged to allow residents to freely mobilise. Residents and families interviewed agreed that they are able to use the main lounges or any of the quiet seating areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>All laundry is completed on-site. Residents and relatives expressed satisfaction with cleaning and laundry services. The service has secure</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>cupboards for the storage of cleaning chemicals. Chemicals are labelled. Material safety datasheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service's policies and procedures. Cleaning staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>A review of rosters evidences that there is at least one staff member on duty on each shift who holds a current first aid certificate. Emergency preparedness plans are accessible to staff and includes management of all potential emergencies. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies. There are sufficient first aid and dressing supplies available. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six-monthly. Emergency equipment, water and food are available.</p> <p>Call bells are situated in all communal areas, toilets, bathrooms and personal bedrooms. Call bells (due to their physical placement) were not evidenced to be within residents reach in a number of resident bedrooms and bathrooms.</p> <p>The service has a visitor's book at reception for all visitors including contractors to sign in and out. Appropriate security systems are in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Resident's rooms are provided with adequate natural light, safe ventilation and in an environment that is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practices and reporting. The clinical coordinator is the infection control coordinator and she is responsible for infection control across the facility. The organisational IC Steering Group is responsible for the development of the infection control programme and its review. The facility review is also completed through the IC programme review internal audit. The infection control programme is well established at Brittany House</p>

		Residential Care. The Infection Control Committee is incorporated as part of the staff meeting. There have been no outbreaks since the previous audit.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Brittany House. The infection control (IC) coordinator has maintained best practice by keeping up to date with infection control updates. The IC coordinator has also completed IC training online through MOH. The infection control team is representative of the facility and is incorporated as part of the staff meeting. External resources and support are available through the community microbiologist, simple solutions and the TerraNova IC Steering Committee that meets bimonthly. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a range of policies, standards (SOP) and guidelines, defines roles, responsibilities and oversight, surveillance, training and education of staff and scope of the programme. The policies and procedures are reviewed every two years or if there is a change to best practice guidelines.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held and has been completed in 2017.</p> <p>The infection control coordinator has received education both in-house and by an external provider to enhance her skills and knowledge. The infection control coordinator has access to the TerraNova IC Steering Group for resources, guidelines best practice and group benchmarking. Infection control is also a component of the wound care competencies completed by RNs. There is also an IC competency completed by all staff.</p> <p>A number of education talks have been provided at handover including</p>

		(but not limited to) preventing UTIs, eye care and hand hygiene.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the TerraNova infection control manual.</p> <p>An individual resident infection form is completed (IC wizard on People Point). Monthly infection data is collected for all infections based on signs and symptoms of infection. These are reported into Simple Solutions benchmarking programme. An infection analysis summary is auto-populated. The IC coordinator has utilised these summaries to identify trends and reduce infections. Graphs, corrective actions and outcomes are shared with staff.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes restraint/enabler management procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings and restraint steering meetings at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had five hospital residents requiring the use of restraints (four bedrails and one lap belt) and four residents with bedrails as an enabler. All enabler use is voluntary. Two enabler resident files were reviewed. The enabler assessment form was completed and signed by both residents. The assessment/evaluation form has been evaluated at least three-monthly.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Only staff that have completed a competency assessment are permitted to apply restraints. The RN, restraint coordinator, GP and manager sign off restraint use. Staff complete competency assessments annually. These are completed with the restraint coordinator. The restraint procedure includes responsibilities for key staff at an organisation level and a service level. The restraint coordinator is a registered nurse and has a signed job description and understands the role and her accountabilities.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraint coordinator, RN, manager and GP, in partnership with the resident and their family/whānau, undertake assessments. A registered nurse is the restraint coordinator.</p> <p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. The files of two residents on the restraint register were reviewed. There was a restraint assessment completed (restraint/enabler & de-escalation evaluation form) in both files. The care plan was up to date and provides the basis of factual information in assessing the risks of safety and the need for restraint. Interventions were documented under the 'behaviour section' of the care plan. Ongoing consultation with the resident and family/whānau is also identified. Falls risk assessments are completed six-monthly and interRAI assessment identifies risk and need for restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used.</p> <p>The assessments reviewed referred to specific interventions or strategies to try (as appropriate) before use of restraint. The care plan reviewed (of two hospital residents with restraint), identified observations and monitoring. Restraint use is reviewed and documented on the three-monthly evaluation form. Restraint is also reviewed at the three-monthly restraint meetings and six-monthly multidisciplinary meeting and includes family/whānau input. An up-to-date restraint register was in place. Monitoring of restraint is documented on the 'People Point' computer programme and links into progress reporting.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred three-monthly as part of the ongoing reassessment for the resident on the restraint register and as part of their care plan review. The family is included as part of the MDR review. Evaluation timeframes are determined by risk levels.</p>

		Monitoring of restraint is documented on the 'People Point' computer programme and links into progress reporting.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed at least three-monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. There is an active organisational restraint steering group. Review of this use across the group is discussed at that meeting and information is disseminated throughout the organisation. The organisation and facility are very proactive in minimising restraint usage. Brittany House Residential Care is focused on minimising restraint and has a goal to reduce the use of restraint by 65% in 2017.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Eight of fifteen incident reports were fully completed to document contact or the reason for no contact with family following an incident. Family interviewed confirmed they are kept informed of any changes to their loved one's health status.	Seven of fifteen resident related incident reports (and progress notes) reviewed did not document contact with family regarding the incidents.	Ensure that accident/incident forms are fully completed to indicate that family have been informed of the incident. 90 days
Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.	PA Low	A call bell system is in place; however, during tours of the building, call bells were not always evidenced to be accessible to residents. Many call bell points were located at floor level in the downstairs bathrooms and were not within resident reach. The ground floor call bell system set up has no way to alert staff that emergency assistance is required versus the usual call bell sound.	i) Call bells were not evidenced to be within residents reach in eleven out of sixty-two resident bedrooms and bathrooms (six resident bathrooms upstairs and five bedrooms downstairs). Since the audit the maintenance man has been working through addressing this and ensuring all call bells have extension calls that now can be reached by residents. ii) The call bell system on the ground floor	(i-ii) Ensure that call bells are accessible and placed within residents reach and that call bells are able to alert of an emergency situation requiring urgent assistance. 60 days

		Both staff working on the ground floor however hold a company mobile phone for use whilst on duty so that they can call for emergency help when needed.	is not able to alert staff that emergency assistance is required. Both staff working on the ground floor however hold a company mobile phone for use whilst on duty so that they can call for emergency help when needed. This has mitigated the risk and advised there has been no incidents identified in response to the call bell system.	
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Brittany House employs a full-time activities coordinator who assists and oversees the programme. The service also employs two activities assistants who work part-time and the service is supported by a number of volunteers. This team provides activities seven days a week. There is a comprehensive activity programme for all residents including young peoples.</p>	<p>Following feedback from the resident meetings the service developed a quality project around improving the activities programme especially for the younger residents. One of the young persons is the team leader for this group. This group has initiated new activities, examples include: Māori wood carving; furniture restoration; weekly movie evenings with snacks; a planned monthly takeaway lunch just for the younger group; karaoke evenings once every three nights; and fundraising alongside the Salvation Army to purchase sweatshirts for needy children with some residents' screen printing the sweatshirts. The residents and activities coordinators interviewed stated the older and younger residents have formed a bond, with some of the younger residents assisting rest home and hospital residents in the home with art and craft</p>

			<p>activities.</p> <p>The introduction of more trips as well as the coffee club group has been very well received. An evaluation of the activities project identified improvement with the activities programme with resident satisfaction increasing from 86% in 2016 to 92% in 2017.</p>
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End of the report.